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EHRs must change for the better

“I want to talk about the elephant in the room!”

The EHR is everywhere—in the exam rooms, at the hospital bedside, in our offices, in meeting rooms and even in the dining rooms. We know from several recent studies that the “promise” of the EHR reducing time for clinical documentation and producing better communication has not been the reality. We are all aware that clinicians now spend more time connected to their computer screens than connected directly with our patients. This must change for the better.

“My role as a physician relies especially on the doctor-patient relationship and that needs both time and ability to maintain eye contact and connection.”

1. We need to separate the two masters of the EHR: the regulatory/billing/coding necessities and the clinical/patient story and care management.

2. Stop using cut and paste. This adds to note bloat and can potentially cause harm if misinformation is carried forward.

3. Imbed a direct link to the State Prescription Monitoring Program (for controlled substances) into the EHR for every patient. My organization did this recently. It is a big time saver.

4. Demand that EHR vendors make it easier to get appropriate billing codes. If most search engines can find the correct diagnosis even when words are misspelled, why can’t our electronic records?

5. The clinic notes should be organized so the assessment and plan is readily available. Perhaps reorganizing from SOAP to APSO notes is one solution.

6. Use team-based documentation for parts of the patients’ story, family history and health maintenance. This allows MAs, RNs and pharmacists to fully do their scope of practice and can reduce the documentation time for the physicians.

7. We need to reduce the regulatory requirements (which drives a lot of repetitive documentation). (see my earlier blog on advocacy)

8. Make sure your practice has at least one EHR “super user” who can help you organize your favorites and effectively use other time savers.

9. Change your EHR password to something that makes you laugh or smile.

In the spirit of positivity, I will offer my own list of things for which I am grateful in regard to the EHR.

I do not have to write out prescriptions anymore.

the EHR can make me aware of potential drug-drug interactions or duplicate scripts.

I have the notes available to me from specialists and others to better care for my patients.

I have an IT team that can help troubleshoot computer issues.

I can access the charts remotely when needed.

Patients can have ready access to their records.

The EHR can become that indispensable tool that fulfills its promise to improve patient care and safety and reduce the time burden on clinicians. We have much more work to do together for this to be a reality.

Carrie Horwitch MD, MPH, is an internal medicine physician practicing in Seattle, Wash. Her column represents her own opinions and not her employer.
Physician burnout
The real reason—and how to fix it

Cover Story

Insider trading
What is it and how to avoid it

Coding tune-up
Three ways to fix your coding process and increase revenue

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How to use modifiers to explain a patient condition and more

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Businesses are expanding into virtual healthcare. Should you?

Working with pharmacists
More practices are bringing pharmacists on staff

Fix declining profit
Don’t panic: Here’s how to respond in a smart way

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Medicine’s gender problem
Disparities between male and female physicians remains a real problem, writes Linda Girgis, MD.

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What this generation of patients wants from their physicians

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Championing solutions to the opioid crisis in a for-profit health system

Change is difficult for healthcare professionals but especially difficult in a for-profit healthcare system setting—especially those systems caring for high-risk populations. Many medical care providers may not realize their aversion to change except after further analysis and reflection.

Admittedly, how we, as people, resist change and how we recognize our own (internal) oppositions is a complicated matter, but it is an even more significant (and morally obligated) hurdle for medical care providers.

In his article Slow Ideas, Atul Gawande, MD, makes a critical observation about delayed acceptance of this analysis. One critical question he asks is why some innovations take off.

Gawande states in his article, “Maybe ideas that violate prior beliefs are harder to embrace.” He hypothesizes that it is difficult to end an activity without any data to back up the claim for why it may not be the best method of execution. He further hypothesizes that without trust and respect, it is difficult for individuals to listen to the enforcer of any new idea.

Let’s take the example of Hahnemann University Hospital in Philadelphia. In 2012, Hahnemann was owned by Tenet Healthcare Corporation, a for-profit entity under a collaborative teaching relationship with Drexel University College of Medicine. The operating room resources allocated for pain management services at this hospital were scarce, and the patient population with substance abuse disorders was both increasing and racially and socioeconomically underserved.

The challenge was clear: How to move the needle when the resources were little to nil and the escalating opioid crisis and demands of patients and physicians were rising. The infrastructure of the facilities was challenging and very few resources were offered to operate the pain center.

Moreover, the pain services were often disorganized since they were siloed and leadership was not clear on how to provide services at the hospital.

MORE ONLINE To read more, visit bit.ly/opioid-crisis-for-profit.

Bloggers

Several doctors shared their personal experiences with what they saw to be obvious gender pay gap discrepancies. A pediatrician in the Midwest that wishes to remain anonymous says that she happened to see the pay stub of male colleague who had similar education, experience, and worked the same number of hours as she did for more pay. She addressed the issue with her employers, who reprimanded her by saying “You should not be discussing others’ pay rates.”

—Heidi Moawad, MD, on the gender pay gap in medicine

“Congress has initiated a series of price-fixing, central planning, bureaucratic, and time-consuming initiatives, such as efforts to push value-based care in MACRA’s Quality Payment Program. These efforts destroy the patient-physician relationship and overburden physicians with a heavy administrative workload. This has contributed to physician burnout.”

—Ken Fisher, MD, on how to save Medicare by allowing patients to choose

Influenza

New research may lead to norovirus vaccine
Study highlights barriers, solutions for keeping up on adult vaccines
New study addresses cost and consequences of poor adult vaccine adherence

For more, visit bit.ly/MEC-vaccines.

To view, visit bit.ly/gun-violence-debate.

Medical Economics is part of the Modern Medicine Network, a Web-based portal for health professionals offering best-in-class content and tools in a rewarding and easy-to-use environment for knowledge-sharing among members of our community.
Nurse practitioners are valuable members of the team—but they aren’t doctors

Nurse practitioners (NPs) can be a valuable member of the healthcare team. They can be trained to do an excellent job to follow up on patients with identified chronic conditions, but they are by no means interchangeable with a licensed primary care physician. Allowing them to practice primary care with little to no supervision makes them equivalent from a practical standpoint.

The training of a primary care physician is markedly more involved and consistent across the country than that of an NP. We are talking 21,000 hours for a board certified Family Practitioner with a nationwide standardized board exam versus anywhere from 3,500 to 6,600 hours with several different certification tests and organizations administering them.

Their relatively limited training does not allow them to formulate an adequate differential diagnosis in some patients presenting for an initial evaluation. Although it is true that one should think of horses when hearing hoof beats, one also needs to be aware of the existence of zebras and that requires the type of training that only a physician undergoes. A patient deserves to have their initial evaluation to be performed by someone with the breadth of knowledge to identify serious conditions with benign presentations. It is also a disservice to patients and an insult to referring physicians when specialists allow Nurse Practitioners to do the initial evaluation in someone with unclear pathology.

It seems that everyone wants to be a doctor, but not everyone wants to go to medical school.

Keith Dinklage, MD
NEW CASTLE, IND.

Author’s idealism is appreciated, but payers still get in the way

I appreciate the sincerity of Rajeev Kurapati, MD, in his essay, “How the modern doctor was created” (November 25, 2018 issue).

He suggests that the science of medicine has beguiled us into seeing patients as a mosaic of symptoms and organ systems, separate from seeing them as complete human beings.

His answer is to slow down, see fewer patients, get off the treadmill. Insurance companies’ control of physicians’ fees, however, have made it impossible to make a decent living and support a family if they slow down, see less patients, work fewer days a week.

This particularly affects young doctors just starting out. It explains why most of them are joining hospital networks for financial security; but the tradeoff is that they’re under pressure to see large numbers of patients and quickly.

The point is that his idealism is admirable and we all need to hear it. But insurer’s interference makes it impossible to achieve.

Edward Volpintesta, MD
BETHEL, CONN.

“Insurance companies’ control of physicians’ fees, however, have made it impossible to make a decent living and support a family if they slow down, see less patients, work fewer days a week.”
Survey: Fewer physicians independent, majority feels burned out

A new survey of U.S. physicians found that physician independence has declined rapidly in the last decade, and that a majority of physicians are feeling overextended and burned out. The survey was conducted by The Physicians Foundation, a physician advocacy organization. Here are highlights from the results:

**Fewer independent physicians**

31% of respondents identified as independent, down from 33% in 2016, and 48.5% in 2012.

- In general, physicians are working fewer hours and seeing fewer patients.
- Employed physicians are working more hours and seeing fewer patients.

**Docs are at their limit**

80% of physicians say they are at full capacity or are overextended.
23% of physicians’ time is spent on paperwork.
78% of physicians said they felt burned out some of the time, often or always.

**Many contemplate a career change**

As many as 46% of physicians plan to change career paths. The most common options were:

- Retiring: 17%
- Plan to find a non-clinical position: 12%

**Patients face difficult impediments to care**

88% of physicians said at least some of their patients have social determinants, such as poverty or unemployment, that pose a series impediment to their health.

What they love and what they hate about practicing medicine

**THEY LOVE:** PATIENT RELATIONSHIPS

**THEY HATE:** EHRs
Optimize your healthcare marketing strategies to win millennials

by ALEX MANGROLIA  Contributing author

HIGHLIGHTS

 Millennials are more focused than older generations on the “wellness” part of their health. It is about balancing all facets of life—from controlling stress levels to cultivating positive relationships.

 Millennials want to choose their healthcare provider or facility by comparing prices and reading reviews.

 Millennials, the generation that comprises 25 percent of the total U.S. population, check their phones on average 69 times every day.

 These digital natives use technology differently than older generations. They prefer to shop online, schedule appointments online, and read online reviews of everything from movies to healthcare providers. Nearly 50 percent of millennials and Gen Xers read online reviews when searching for a healthcare provider, compared to 28 percent of seniors and 40 percent of baby boomers.

 The first thing millennials, or Generation Y members, do when they have a question about anything, including their own health, is grab their phone. Whether that means querying Google, emailing a friend, or checking their online groups for information, the desired outcome is the same: Millennials want reliable information without compromising convenience.

 They want healthcare to be more convenient and do not want to miss work for a medical appointment. Instead, they would rather go to urgent care to get the services they need because it is quicker and easier to be seen—even if there’s a queue. Statistically speaking, millennials are likely at the peak of their health and don’t need frequent appointments to manage several chronic conditions or medications.

 The Health Industry Distributors Association surveyed 1,000 patients, and the results highlighted millennials’ desire for convenience, speed of service, and cost-effectiveness. Here are some of the findings:

 ❚ Millennials are more than twice as likely as older generations to search healthcare providers on third-party review sites like Yelp and Angie’s List.
 ❚ Almost 43 percent visited an urgent care in the past year, and nearly 23 percent visited a retail health clinic.
 ❚ 33 percent said they waited too long to receive care.
 ❚ 41 percent postponed seeking healthcare because they said it was expensive.
 ❚ 60 percent said cost was a significant factor when evaluating a provider.
 ❚ 32 percent said they would switch providers if they were dissatisfied.

 WHAT MILLENNIALS WANT FROM THEIR PHYSICIANS

 Technology plays an integral role in helping millennials manage their well-being, from wearable devices to calorie-tracking apps to patient portals to online communities.

 Millennials are educated customers who respect their providers’ education and skill sets, but they do not view physicians as the only health resource. So, in order to stay ahead of the game, healthcare providers must understand how their millennial patients gather and consume healthcare information.
Here is some insight into what they expect from their providers:

**Affordability determines care.**
Strapped with all kinds of loans, cost is the biggest factor most millennials consider when making critical decisions, including their own healthcare. Unlike older generations, millennials pick insurance plans based on price.

In addition, almost 46 percent of millennials are willing to go out of network just to save money. According to a survey, nearly 54 percent of millennials are willing to delay healthcare because of cost. Delaying healthcare can have long-term implications because serious health problems may not be identified until later, when treatment options are more expensive and less effective.

**Technology enhances care.**
Emails, texts, and push notifications through apps are preferred methods of communication to phone calls and mailed appointment reminders.

When looking to establish lasting relationships with millennials, it is best to consider the technological trends and use familiar platforms. Most millennials would prefer providers use an app for scheduling appointments for a more efficient experience and recommend preventive care apps to help simplify their life. Millennials want to choose their healthcare provider or facility by comparing prices and reading reviews, which are increasingly important with the rise of high-deductible health plans.

**Relationships affect care.**
When millennials need medical attention, they turn to search engines and other online platforms such as WebMD before visiting their healthcare provider.

According to a report, nearly 50 percent of millennials do not have a personal relationship with their physician. In fact, most millennials visit the doctor less than once a year and do not even schedule preventive care visits. They are also likely to cancel an appointment if they are too busy.

Millennials are more focused than older generations on the “wellness” part of their health. For Generation Y, staying fit is not about not getting sick, it is about balancing all facets of life—from controlling stress levels to cultivating positive relationships.

**MEETING THE HEALTHCARE NEEDS OF MILLENNIALS**

Millennials seem to be displaying a reluctance to engage with the existing healthcare system. This trend is driven by a number of factors, including any unpleasant experiences with healthcare providers, recent changes to the American healthcare industry driven by the Affordable Care Act, and a general lack of trust in healthcare institutions.

In addition, millennials are more conscientious about costs, especially those with high-deductible health plans. As a result, they seek advice and care from a wide range of sources and have a more diverse interpretation of health information than older generations.

Given millennials’ declining engagement with the traditional healthcare system and increased self-dependence, healthcare practices need to meet millennials where they are—in their social networks and on emerging online healthcare and channels. By providing preventive healthcare apps and self-help resources, doctors can help millennial patients feel more empowered to make the right choices while gently steering them toward the traditional healthcare system, as necessary.

When it comes to attracting and engaging your millennial patients, keep four things in mind: convenience, patient experience, cost effectiveness, and credibility. In order to keep up with millennials’ desires for care, healthcare practices will need to provide quicker options like online check-ins and one-stop healthcare. With these convenient and tech-friendly healthcare alternatives, practices can attract and retain millennial patients.

Opportunities exist for healthcare providers who can free themselves from their tunnel vision of what healthcare has traditionally been and see the potential for how healthcare can be delivered through products and services that help millennials enhance their lifestyle and well-being.

Alex Mangrolia is director of marketing and product development for Practice Builders, a healthcare marketing and consulting firm for healthcare practices, hospitals and clinics.

“Given millennials’ declining engagement with the traditional healthcare system and increased self-dependence, healthcare practices need to meet millennials where they are—in their social networks and on emerging online healthcare and channels.”

57% of doctors reported that millennials are likely to seek a one-time appointment instead of developing a relationship with their physician.

Source: Sermo
How the system works against you—and what to do about it

by JEFFREY BENDIX Senior Editor

P ediatrician Karen Ailsworth, MD, began her career with a multispecialty practice in Baraboo, Wisc. She enjoyed the job at first, but a couple of years after she started an HMO bought the practice, and soon afterward conditions began to change for the worse.

“They wanted us to be more and more productive, like we had to see a patient every 15 minutes,” she recalls. It wasn’t long before she began experiencing a common symptom of burnout: anger at her patients. “I started feeling like, ‘don’t tell me your problems, I don’t have the time. Just make my life easy.’ And that wasn’t the way I wanted to practice.”

Ailsworth stuck it out for 16 years, finally quitting in 2010 and pursuing locum tenens work before landing a less stressful position at an Indian Health Center.

“It felt like the bean counters were in charge, and it wasn’t about patient care any longer,” she says of her former practice. “I didn’t feel like we got recognized for what we did. It wasn’t like I wanted an award, but more like recognizing not every patient fits into a 15-minute slot, and doctors aren’t just widgets in a factory.”

Ailsworth’s story would no doubt be familiar to many physicians, both for the feelings of burnout she experienced and the reasons behind them. Like her, doctors are reacting not just to the ordinary frustrations of workaday life but to obstacles produced by the healthcare system itself. These include, among others, the mounds of paperwork they must contend with, unhappiness over loss of professional autonomy and the ongoing decline in long-term relationships with patients.

“What we hear from doctors repeatedly is, ‘I went into healthcare to help people, but I spend my day typing into a computer or on the phone doing prior authorizations and I feel like my time is being wasted on all of these things instead of focusing on taking care of my patients,’” says Clif Knight, MD, FAAFP, a board member of the National Academy of Medicine’s Action Collaborative on Clinician Well-Being and Resilience, a group fighting burnout in healthcare. “And over time doctors lose that connection of why they went into medicine and start...
wanting to do something else because they feel like they’re just wasting their time.”

**BURNOUT ON THE RISE**

Whatever its source, there’s little doubt that feelings of burnout—which the AMA defines as “a stress reaction marked by depersonalization, emotional exhaustion, a feeling of decreased personal achievement and a lack of empathy for patients”—are widespread and growing. In the Physicians Foundation’s “2018 Survey of America’s Physicians: Practice Patterns and Perspectives,” 77.8 percent of respondents reported having feelings of professional burnout either sometimes, often or always—up from 74 percent in 2016.

Similarly, a 2016 study of the prevalence of burnout, published in the Mayo Clinic Proceedings, found that 54.4 percent of the physicians surveyed reported at least one symptom of burnout in 2014 compared with 45.5 percent in 2011.

The fact that so many doctors express similar feelings of frustration and alienation is itself evidence of deep-seated dysfunction in the nation’s healthcare system, according to many experts. “We feel caught between doing the work our patients need and the work we feel is mandatory in our environment,” says Christine Sinsky, MD, an internist and vice president of professional satisfaction for the AMA. “And when those competing demands are not aligned, it creates a situation that is simply unmanageable for many physicians and other health professionals.”

Some who have studied the problem believe “burnout” doesn’t accurately capture doctors’ reactions to the hurdles they face in trying to care for their patients. They describe it instead as “moral injury,” a term first coined to describe soldiers’ responses to the dilemmas they frequently face during wars. (See sidebar on page 23.)

**THE ROLE OF EHRs**

Not surprisingly, a major culprit in creating unmanageable situations for many physicians are electronic health records. The technology’s shortcomings—lack of interoperability, poor user interface and interference with face-to-face patient care, among others—are well known by now, and a frequently cited cause of burnout. But their impact on doctors’ morale can extend beyond frustration with the technology itself by surfacing organizational dysfunction in hospitals and healthcare systems, says Mark Friedberg, MD, MPP, senior physician policy researcher with the RAND Corporation.

Friedberg notes that in large organizations, non-clinician executives often are the ones deciding which EHR system to purchase and how it will be configured with little input from the doctors who will be using it. That means patient care may not be an important part of the decision.

“If you’re a physician in a hospital telling management that this technology you use every day is inadequate, and you’re being told that [the EHR] isn’t for you but is for billing and comply—

“We feel caught between doing the work our patients need and the work we feel is mandatory in our environment. And when those competing demands are not aligned, it creates a situation that is simply unmanageable for many physicians and other health professionals.”

—CHRISTINE SINSKY, MD, INTERNIST, VICE PRESIDENT OF PROFESSIONAL SATISFACTION, AMA
ing with Medicare, that kind of response is a surefire path to burnout,” he says.

**LOST AUTONOMY**

A second underlying source of burnout for many doctors, experts say, is loss of autonomy, as more physicians leave independent practice for employment with hospitals and health systems. While this relieves them of the administrative responsibilities that come with owning a practice, it also means they have less control over working conditions, says Robert McLean, MD, FACP, president-elect of the American College of Physicians.

“When you become part of a large system, you’re no longer a self-employed person who can determine their own work or call schedule,” he says. “A lot of those little decisions you used to make [as a practice owner] while they could become headaches, they also contribute to the feeling that you’re a self-actualized person, and that gets lost as an employee.”

But even doctors in independent practice no longer enjoy the degree of autonomy they once had in caring for patients, McLean notes, thanks to the proliferation of payer-imposed requirements such as prior authorizations and quality metrics. Meeting these requirements is not only time-consuming but runs counter to the emphasis on decision-making doctors receive during their training.

“Now a lot of those decisions can’t proceed the way the doctor thinks they should because there’s the ever-present middleman who’s following the golden rule, meaning he or she with the gold makes the rules,” he says. “So when someone else is paying the bill, to some extent they’re going to insert themselves in the process by determining how much they’re going to pay for treatment.”

Another underlying factor leading to feelings of burnout among doctors is the decline in long-term relationships with patients, according to the AMA’s Sinsky.

“I think we have come to conceptualize healthcare as a series of independent transactions that can be distributed among providers willy-nilly, so that we have lost sight of the value that’s derived from relationships,” she says. “That value comes both from the emotional satisfaction doctors derive from their relationships with patients, and the quality of care they are able to provide.

“I can help guide my patients and make better diagnoses if I know them better,” she says. “And not every bit of knowing a patient is captured in the EHR or can be transferred from one physician to another.”

**ERODING TRUST**

An additional cause of burnout has been an erosion in the belief that everyone in the healthcare industry is acting in the best interest of patients, rather than their own bottom line.

Knight cites the example of the extensive documentation that now accompanies evaluation and management codes, a widespread source of frustration among primary care doctors who are the main users of the codes.

“The coding documentations don’t really result in improved value from a clinical standpoint,” he says. “I think it boils down to a lack of trust that physicians won’t overbill.”

The same logic applies to payers who require step therapy and prior authorizations before agreeing to pay for expensive treatments and medications.

“I think all these strategies have some degree of validity to them, but they’ve resulted in stealing time from physicians that they’d rather spend focus-—”

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**Q:** Do you feel burned out?

**84%**

**Yes**

| **Source:** Medical Economics online poll, December 2018 |

**16%**

**No**

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“When docs have been experiencing death by a thousand cuts, we can’t just give them a bandage, we have to try to remove the knife. You can’t yoga yourself out of burnout.”

—ROBERT MCLEAN, MD, INTERNIST, PRESIDENT-ELECT, ACP
IS IT BURNOUT—OR MORAL INJURY?

“Burnout” is the word most commonly used to define the feelings of exhaustion, frustration and cynicism prevalent among growing numbers of American doctors. But some experts who have studied burnout think the term doesn’t accurately capture these doctors’ emotions or the situations from which they arise, preferring instead the term “moral injury.”

Wendy Dean, MD, formerly a psychiatrist and now senior medical officer at the Henry M. Jackson Foundation for the Advancement of Military Medicine, says moral injury occurs when doctors feel they are impeded from doing what is best for their patients. Impediments can take a variety of forms, such as an insurer’s unwillingness to pay for a medication or procedure, limits on appointment times set by the doctor’s employer, or the need to score highly on patient satisfaction surveys.

“How do you answer to all those masters and do what you pledged under the Hippocratic oath, which is always to work in the best interests of the patient?” Dean asks. “With every patient encounter you’re in a bind and not able to do what you were trained to do. You can tolerate that if it’s an occasional event, but when it happens every day it becomes a crushing burden.”

Moreover, she says, labeling a doctor burned out implies a condition that it’s the doctor’s responsibility to fix, rather than the result of a systemic failure. “The way I think of it is that physicians are very, very eager to take care of their patients. But sometimes we can’t do it. We’re not allowed.”

Adam Schwarz, MD, an internist in Hanover, N.H., spends a great deal of time talking with unhappy physicians in his role as a “well-being champion,” part of the American College of Physicians’ Physician Well-being and Professional Satisfaction” initiative, designed to combat burnout among ACP members. But the majority of doctors he encounters “identify more with the moral injury mindset than they do burnout,” he says.

The difference, he says, is that burnout implies feelings of being overwhelmed by the demands of being a physician, whereas “moral injury speaks to the sense that they have fallen below what they think standards should be or they’re cutting corners due to productivity requirements in ways that make them feel uncomfortable. “It’s not that these docs aren’t working really hard. It’s that they’re having to make decisions that go against their core beliefs” he says. “It’s that alteration of the moral compass that makes docs feel like they’re betraying their patients.”

Dean believes the growing popularity of direct primary care models stems in part from doctors’ desire to avoid feelings of moral injury. She cites her own decision to adopt the DPC model when she was in practice. “The only way you could make a living taking insurance was to run people through at 12 an hour,” she recalls. “And I wasn’t going to do that because it’s not good patient care.”

“What physicians are saying is, ‘take the insurer out from between us and the patient,’” she adds. “Take the EHR out. Allow us the time to get to know who my patient is and what they want.”

“With every patient encounter you’re in a bind and not able to do what you were trained to do. You can tolerate that if it’s an occasional event, but when it happens every day it becomes a crushing burden.” —WENDY DEAN, MD
HOW ONE ACO TOOK ON BURNOUT

“Physicians hold themselves to high standards and become stressed when they can’t live up to them. This is exacerbated when they don’t have a voice.”

Employment cannot be seen as an easy path to physician engagement because that strategy won’t carry you across all initiatives. While many of our primary care doctors are employed, most of our hospital and ED doctors are independent. At the end of the day, it’s all about the patients. We need expertise from physicians, whether they’re employed or are one of our independent partners.

It’s essential to listen to everyone’s perspectives. We asked our providers: What feedback or data do you need? How can we build our infrastructure to better support you and your patients?

MAKE PHYSICIANS YOUR STAKEHOLDERS

Robert Phillips, MD, PhD, our system chief medical officer, established the Physician Engagement Resiliency Taskforce (PERT). The goal of the task force is to bring primary care physicians, specialists, residents, surgeons, process engineers, residency directors, and analysts together to share their perspectives on how to improve physician satisfaction. PERT meets quarterly to determine what practical action items and programs make sense to pursue as a cross-functional team. Those decisions are informed by our physician engagement survey. Subgroups are working on programs to address specific issues the survey identified by finding fixes to inefficient workflows and promoting physician well-being. For example, one of our subgroups worked on enabling oncologists to work at the top of their license by removing administrative burdens.

By Julia Andrieni, MD and Michael Udwin, MD

Cardiologists, and many others to find ways to reduce readmissions and proactively avoid and manage chronic conditions.

At the system level, it’s wonderful to be able to congratulate these clinicians on their strong partnership and focus on the patient. For every clinician who feels like they have the support of a team and can own their next steps, our ACO gains a smart resource ready to take an opportunity and run.

We recognize that each primary care doctor has a unique communication style and preference. As we have expanded our integrated network, we began by soliciting feedback on how each doctor prefers to both receive and convey patient information—by secure emails or texts, faxes or EHR messages. We have worked tirelessly to communicate in the most meaningful and efficient manner indicated by the physician.

Ask any primary care physician or specialist what provides the greatest satisfaction and you will almost always universally hear “making a difference for my patients.”

In an effort to improve care for our patients with diabetes, we began by sharing outcomes with a select team of primary care providers, pharmacists, and endocrinologists. We elected to use a multi-disciplinary team to pursue diabetic patients who were not adherent to scheduled visits to better understand barriers to care they encounter. The physicians recognized that this strategy holds the promise of averting worsening diabetic complications while improving patients’ quality of life.

It’s essential to take a look and be honest with yourself to see where you are in the physician engagement process. We’re trying to find ways to improve processes and partnerships every day, and even have some fun along the way.

Julia Andrieni, MD, is vice president for population health and primary care and president and CEO for Houston Methodist Coordinated Care (HMCC). Michael Udwin, MD, is vice president of clinical transformation for management consulting firm Evolent Health.
"Over time doctors lose that connection of why they went into medicine and start wanting to do something else because they feel like they’re just wasting their time."

—— CLIF KNIGHT, MD, BOARD MEMBER, NATIONAL ACADEMY OF MEDICINE’S ACTION COLLABORATIVE ON CLINICIAN WELL-BEING AND RESILIENCE

Policy

Physician burnout

“Over time doctors lose that connection of why they went into medicine and start wanting to do something else because they feel like they’re just wasting their time.”

—CLIF KNIGHT, MD, BOARD MEMBER, NATIONAL ACADEMY OF MEDICINE’S ACTION COLLABORATIVE ON CLINICIAN WELL-BEING AND RESILIENCE

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cesses are being implemented,” he says.

“It’s a confluence of forces that stresses the whole industry and doctors tend to blame ourselves for the fact that the system is inefficient and it creates a cycle of stress, overwork and negative self-judgment. And I think that’s a big part of what’s producing burnout.”

LOOKING FOR SOLUTIONS

Despite the seeming intractability of the problems behind burnout, there are signs that healthcare institutions and policymakers are beginning to address them.

Among these are CMS’ “Patients Over Paperwork” initiative and the AMA’s STEPS Forward program, and the detailed recommendations for combating burnout contained in the Institute for Healthcare Improvement’s “Framework for Improving Joy in Work” and the ACP’s “Putting Patients First By Reducing Administrative Tasks in Health Care” papers.

Along with these is a growing recognition of the responsibility hospital systems and other healthcare institutions have in alleviating burnout, since they now employ a large percentage of the nation’s healthcare providers.

Experts say that role extends beyond just offering wellness classes or helping doctors become more resilient. The ACP’s McLean notes that while such initiatives have a role in combatting burnout, they don’t get at the underlying causes.

“When docs have been experiencing death by a thousand cuts, we can’t just give them a bandage, we have to try to remove the knife,” he says. “You can’t yoga yourself out of burnout.”

Moreover, offering wellness programs without acknowledging the systemic causes of burnout can wind up being counterproductive, says Bohman. “Often the doctor’s attitude is, ‘you’re telling me one more thing I have to do. When am I going to exercise or meditate when I’m already doing medical records for three hours at home every night?’”

Instead, Bohman says, hospital systems need to focus more on getting input from “frontline workers”—clinicians—in decisions and policies that affect how they do their jobs. He cites the example of how University HealthCare Alliance sought to come up with a universal set of quality metrics for its primary care providers.

“There are hundreds of different things you can measure to assess quality,” says Bohman. “So we asked our physicians, ‘what do you think are the things that have the most impact on patients, that improve clinical outcomes the most?’”

UHA is starting with 11 quality metrics that include common ones such as smoking cessation, depression screening and blood pressure control.

“It’s a small number of the ones that we need to ultimately take care of but we’re building the systems and the processes to do that in a way that doesn’t rely on doctors putting sticky notes on their computers to remember things,” Bohman says.

In addition, he says, institutions can reduce burnout by focusing on physician engagement, which requires developing a culture of trust and mutual respect.

“Assuming good intent on the part of every clinician is the key to improving engagement and wellness overall,” he says. “I’ve been an administrator for 10 years and I can’t remember getting burned by assuming a physician is trying to take good care of a patient. People don’t go into medicine with any other intent.”
The Food and Drug Administration (FDA) has drafted new guidance related to medical device cybersecurity and the relationship with HIPAA.

The guidance defines cybersecurity as "the process of preventing unauthorized access, modification, misuse or denial of use, or the unauthorized use of information that is stored, accessed, or transferred from a medical device to an external recipient." Translated into "HIPAA language," this requires the availability and integrity of the device—and its data—to remain intact.

The broad scope of the guidance encompasses FDA medical device premarket submissions for effective cybersecurity risk management, continued cybersecurity management to reduce the risk of physical harm to patients, and satisfying HIPAA.

While not binding at the moment, the guidance is important because it references laws that are in effect. The guidance incorporates HIPAA’s Privacy Rule, Security Rule, and Breach Notification Rule as well as the Federal Food, Drug, and Cosmetic Act and related laws (e.g., the Medical Device Amendments of 1976) for branding and labeling provisions.

The guidance identifies two types of devices, Tier 1 and Tier 2. Tier 1 devices are said to carry a higher cybersecurity risk and have two associated criteria:
- capable of connecting (e.g., wired or wirelessly) to another medical or non-medical product, a network, or the internet
- a cybersecurity incident affecting the device that could result in patient harm to multiple patients.

Tier 1 devices include pacemakers, brain stimulators and nerve stimulators. The guidance makes sense given the parts of the body that are affected by the devices.

In contrast, a Tier 2 device is “[a] medical device for which the criteria for a Tier 1 device are not met.” This includes an electronic device that creates, receives, maintains, or transmits protected health information (PHI) or is used in medical treatment but does not impact a body part vital to life.

The guidance recommends complying with the National Institute of Standards and Technology (NIST) and the Federal Information Processing Standards (FIPS). This should not come as a surprise for two reasons. First, the government is required to use these standards internally. Second, both NIST and FIPS are expressly stated in a variety of laws and regulations, including the HIPAA Final Omnibus Rule.

There is a specific section in the guidance entitled Maintain Confidentiality of the Data. The FDA intertwines HIPAA and the obligations between a covered entity and a business associate as well as maintaining data confidentiality. In this context, confidentiality falls under HIPAA.

For the purposes of this guidance, other harms such as loss of confidential PHI are not considered patient harms. Although protecting the confidentiality of PHI is beyond the scope of this document, it should be noted that manufacturers and/or other entities, depending on the facts and circumstances, may be obligated to protect the confidentiality, integrity, and availability of PHI throughout the product life cycle in accordance with applicable federal and state laws.

While physicians may not be involved with the cybersecurity of the device, they are still obligated to comply with HIPAA and the HITECH Act. Physicians should do their due diligence on companies in relation to those entities’ compliance with federal law.
INSIDER TRADING
What it is and how to avoid it

by MILLY DAWSON Contributing author

Doctors often have opportunities to gain nonpublic, insider knowledge about new drugs, devices, and other healthcare innovations being developed by publicly traded companies. A doctor may acquire such information by sitting on a firm’s board of directors, serving as an expert consultant, or helping to run clinical trials whose outcomes can affect the value of a company’s stock.

Insider trading occurs when an individual possessing such inside information makes investment decisions based on it, explains Michael S. Sinha, MD, JD, a research fellow in therapeutic science at the Harvard-MIT Center for Regulatory Science at Harvard Medical School. It’s important to know how to avoid it.

Physicians need to proceed with care when they acquire inside intelligence, that is, material information that could alter a healthcare company’s share price and that is not publicly available. The law prohibits a clinician with access to such inside information from buying or selling stock based on such information and keep it strictly to themselves.

TEMPORARY INSIDERS ARE STILL INSIDERS
Importantly, the law considers consultants who gain access to inside information during a temporary position with a company, such as clinical researchers, to be insiders, according to a recent JAMA Internal Medicine article whose lead author is Aaron S. Kesselheim, MD, JD, an associate professor of medicine at Harvard Medical School and director of the Program on Regulation, Therapeutics, and Law at Brigham and Women’s Hospital.

“Temporary insiders are subject to the same rules as company management and full-time employees,” the authors note.

PITFALLS TO AVOID
There are two basic traps that people fall into with insider trading, explains Steven W. Schuster, JD, a partner at McLaughlin & Stearn, a New York-based law firm.

The first trap consists of an officer, director, or employee of a company taking advantage of knowledge they have obtained through their position with the firm. For example, a physician might observe that a new drug they have been given to test is either a great success or an utter failure. These results amount to material inside information and trading on it would be illegal, says Schuster. Or a doctor might know that a certain drug or device is about to be approved or disapproved by the FDA. These kinds of situations are what people traditionally think of as inside trading, Schuster explains.

The second trap involves a person with inside information tipping off somebody else who then trades in the shares, says Schuster.

In some cases, the the person receiving inside information will share his or her monetary gains with the person providing the tip. However, such sharing of the illegal profits does not have to occur for insider trading to have taken place, says Schuster.

Insider trading can result in both civil and criminal charges. Often, people convict-
ed of insider trading are required to return any profits accrued in the 12 months prior to their prosecution, wrote Kesselheim’s team. The penalties depend upon the extent of the transgression and the amount of illegal gains, and can also include imprisonment, Sinha explains.

What’s more, a person need not actually profit from insider trading in order to be guilty of committing securities fraud, and to be liable to prosecution, according to Kesselheim.

**WAYS TO AVOID INSIDER TRADING**

**Read the fine print**
As described above, physicians often engage with publicly traded companies in various ways, such as serving on boards or as expert advisers. “In these cases, the physician is almost always asked to sign confidentiality or nondisclosure agreements before serving in such roles. Carefully read and then reread the terms of such agreements before you sign them,” says Sinha.

If you don’t understand aspects of the agreements, seek immediate clarification from a representative of the company asking you to sign, Sinha adds.

**Before you buy or sell stock, consider the source of the information prompting the trade**
When a doctor receives information about a public company through their professional activities, they have an obligation to consider the source of the information and whether it has already been made public before trading on it, says Sinha.

“There is a big difference between, ‘I read it in Bloomberg Businessweek’ and ‘I heard it during a company board meeting,’” he says. When in doubt, he advises, do not trade in a stock, even if the information came to you from family or friends.

**The rules apply everywhere and anywhere**
Schuster gives this example: A doctor might socialize with an old friend who works for Disney, and the friend might mention that visitors to the theme parks are up 30 percent for the current year.

The doctor must determine if that information has already been made public or not. If the information is not yet widely available, the friend may expect the doctor to refrain from trading on the basis of it.

If the doctor did buy or sell Disney stock after that conversation, both he or she and the friend may have broken the law.

“Information received in a social setting is a gray area, but when in doubt, don’t trade on it,” says Schuster. The friend may not be guilty if he expected the visiting physician to keep the comments on attendance confidential.

**Do trade freely on insights and ideas you develop yourself**
A physician may have extensive knowledge of a particular illness or a certain type of surgery. He or she may then read in the paper that a certain company is about to invest heavily in an approach that the doctor thinks is going to work or is not going to work, says Schuster. In that case, the physician is free to trade and to advise others to trade in the stock, he says. “You’re using your knowledge and public information. There’s no expectation of confidentiality.”

A doctor would also have the green light to trade, he says, based on clinical observations, insights and intuitions. “Say you’re using a device and it’s just not working well. Or maybe you observe how patients react to a new medication. Trade on it. Tell people about it,” says Schuster. “You’re not getting those ideas from anyone at the company.”

But if a doctor learns about the underperforming device or the fantastic new drug from someone who has a relationship with the company making the device or drug, he or she must not trade on that information or reveal it to anyone else, says Schuster.
Maximize reimbursement by concentrating on coding

by BEN COLTON AND CHRIS GASPARD Contributing authors

Developing a coding and compliance infrastructure that is both appropriately sized and equipped can be tricky for many independent and hospital-based physician groups.

The tug-of-war that occurs when trying to maximize revenue without compromising compliance with professional fee billing can be daunting, especially when placing equal focus on productivity and performance.

In some cases, just bringing this topic to the forefront of discussions with clinical and management teams can be problematic, as coding and compliance specialists may be viewed as impediments to productivity.

However, with the preponderance of recovery audit contractor (RAC) audits, complexity of ICD-10 coding, and changes in payer reimbursement policies, many organizations are now realizing the importance of enhancing their coding infrastructure to ensure success.

WHY IS CODING IMPORTANT?
The coding process is no easy task—there are more than 8,000 CPT codes and 69,000 ICD-10 diagnosis codes to choose from, as well as a litany of complex payer and regulatory guidelines to follow, in order to code accurately.

Moreover, organizations utilize a wide array of resources and workflows to complete the coding process. Some require providers to select codes via an EHR or encounter form, while others utilize support staff to abstract directly from the medical record, and each approach has its own benefits and drawbacks.

The challenges associated with billing and collections are not new, as inadequate attention to coding has always had the potential for high-cost repercussions (e.g., increased billing lag, unnecessary denials, increased cost to collect).

In addition, the Office of the Inspector General’s ongoing focus on RAC audits for evaluation and management (E/M) coding signals increasing scrutiny on physician billing in the ambulatory setting, adding high audit and recoupment costs (or worse) to the list of challenges.

For an organization to successfully manage the tug-of-war between cost and benefit for its coding and compliance program, it must first recognize the importance of the functions provided by its revenue cycle teams.

WHAT IS GOOD PERFORMANCE?
High-performing organizations maintain coding and compliance programs that appropriately balance revenue maximization, coding compliance, and costs to ensure each visit is coded for optimal reimbursement.

All of the coding and compliance functions detailed in the article below play an active role in fostering an organization’s overall success, and should be evaluated to see if there are opportunities for improvement within your own organization.
Each activity is equally important builds upon the others to drive consistent professional fee coding.

The three areas that should be considered are:

- pre-bill coding activities,
- audits and compliance and
- education and feedback.

**1 PRE-BILL CODING STRATEGIES**

Develop consistent coding policies and practices across the organization.

- Coding and compliance policies should be established based on payer- and specialty-specific guidelines. For example, some payers will reimburse for certain coding events that Medicare will not. Organizations shouldn’t forfeit reimbursement opportunities by instituting an unnecessarily rigid compliance program.

- A communication plan should be developed to inform providers or abstracting coders of payer- and specialty-specific policies. The plan should document the source/rationale for each policy to facilitate buy-in and support.

- Identify true coding work, and determine which tasks can be automated and which should be completed by the provider.

- Organizations should review coding workflows to determine if low-risk encounters can utilize technology, such as code selection tools or custom edits, to improve the coding process and minimize manual interaction by providers or staff.

- Where possible, certified coders should be responsible for reviewing high-risk code selection and abstracting complex procedures to maximize reimbursement and reduce errors.

- Ensure staff are appropriately deployed to increase efficiency.

- Based on updated coding workflows, a review of historical, specialty-specific coding volume is necessary to understand how coding staff should be structured and deployed to meet the anticipated volume of coding abstraction, edit, and denial work.

- In certain instances, it may be beneficial to review the usage of third-party coding support for low-volume/high-complexity specialties.

**Practice spotlight**

With more than 1,600 providers across Utah and Idaho, Intermountain Healthcare is widely recognized as a leader in clinical quality improvement and efficient healthcare delivery.

Intermountain Health developed a model that prioritizes provider audit and education over coder abstraction. Generally speaking, under the model:

“When you disconnect doctors from billing, their documentation tends to suffer.”

providers are responsible for their own coding and charge entry; however, approximately 50 coding-certified consultants meet with the providers regularly to discuss areas of opportunity identified from audits and denials. It is important to note that given the complexity of select areas, coders are utilized to support procedural coding for orthopedics, cardiology, and neurosciences.

The rationale for Intermountain’s model is based upon the notion that educated providers need to clearly understand their role in the revenue cycle, as well as their exposure to risk. As Adam Freebairn, director of professional documentation and coding at Intermountain, puts it: “When you disconnect doctors from billing, their documentation tends to suffer. They also tend to forget that they are ultimately accountable for the accuracy and compliance of their coding, regardless of whether a coder abstracted from the record.” In addition, the model is described as being a reaction to the expense and challenges associated with recruiting. According to Freebairn, “our research has found that coders are no more accurate than physicians that have received coding education and have the right tools in place. On top of that, it is hard to find great coders.”

**2 AUDITS AND COMPLIANCE**

Design thorough provider and coder audit programs.

- Annual audits should be completed, and results should be shared with each provider and abstracting coder.

- Certain specialties may require different degrees of E/M coding or procedure audits; however, in general, specialties should have
a consistent quantity of encounters reviewed during each audit cycle.

- Audits should focus on compliance, not revenue maximization.

Establish and enforce accuracy standards across the organization.

- Providers or coders who are performing below a predefined accuracy rate should be coached and re-audited within a probationary period.
- New providers or coders should be audited and coached more frequently until a predefined accuracy rate is attained.
- Policies should include a disciplinary action plan for providers or coders who fail to meet organizational standards.

Periodically review coding policies and procedures to ensure compliance is maintained.

- Compliance staff should periodically review and update coding policies or procedures to ensure language is consistent with changing payer requirements.
- Policy updates should be communicated regularly and made easily accessible across the organization.

**EDUCATION AND FEEDBACK**

Develop an education program that is both proactive and reactive.

- A consistent feedback loop should be established between providers and coders, to include real-time feedback on error trends, tips, changes made to charges, etc.
- Providers and coders should receive periodic and ongoing coding education to better understand compliance expectations and documentation improvement opportunities to allow for optimal reimbursement.

Review coding trends to identify risks or education opportunities.

- Organizations should consider establishing a coordinated education team that includes coding denial resources, as this will allow education to be tailored to denial trends across payers and/or specialties.
- A periodic review of provider or abstracting coder E&M code selection can identify potential compliance risks and allow for targeted education and issue resolution.

Monitor the use of educational material throughout the organization.

- The development of a central education repository with user tracking can ensure material is consumed across an organization.
- Continuing education requirements should be reviewed annually and standardized, particularly for staff who require ongoing education to meet accreditation needs.

**How to determine staffing levels**

**Quantify the work**

Review historical coding and compliance activity volumes (e.g. charge review, edits, abstractions)

Determine future needs of new activities

Estimate the growth within the organizations

**Determine the Throughput**

Calculate throughput by task for the activities identified

If historical values or KPIs don’t exist, perform a time study

Further segment tasks by complexity as needed

**Calculate the Staffing Need**

Determine the time needed to accomplish each task to estimate FTEs

Incorporate continuing education and other value-add activities to staff responsibilities to determine the true FTE need to accomplish the work

“For an organization to successfully manage the tug-of-war between cost and benefit for its coding and compliance program, it must first recognize the importance of the functions provided by its revenue cycle teams.”
While education is listed last in this series of functions, it is by no means least important. Creating something of a "chicken-or-egg" scenario, provider education needs to be informed by policy and audit, but also influences the ability to effectively perform.

PROGRAMS ORGANIZATION
For most organizations it is infeasible to have certified coders abstract and/or review every professional encounter.

To that end, the ideal operational structure is a function-based model, where coders are deployed to support critical activities based on their skill sets and expertise, while providers maintain a high degree of responsibility in the coding process for more routine encounters.

In this model, illustrated below, the production team (responsible for abstraction, edits, and coding denials) and the audit team (responsible for compliance audits) provide trends/feedback to the education team, which in turn acts as a resource for providers by communicating issues and opportunities for improvement.

Given that each team is responsible for defined tasks, the best practice model enables consistency and quality and allows management to easily measure/monitor results. Work standards and performance expectations should also be established to confirm adherence to policies and protocols and ensure proper management of work volumes and backlogs.

Additionally, it should be noted that the audit team reports to a separate authority from the production team. This reporting structure helps guarantee that chart reviews are focused solely on compliance and are not influenced by cash opportunity.

That said, despite the segregation of duties, it is important that all members of the infrastructure adhere to a common set of policies and that teams are led by qualified individuals with deep coding expertise.

Finally, while the model above describes distinct teams, there may be instances where qualified coders would be responsible for multiple functions (e.g., audit and education)—functional duties should be driven by size/necessity of the coding or compliance work.

HOW SHOULD PROGRAMS BE STAFFED?
While system tools and automation should be used where possible, the final step in establishing a successful coding and compliance program is to review the staffing model to ensure:

1/ The appropriate number of resources are working in unison to complete the coding and compliance activities required; and
2/ The work is segmented and structured in a way that allows for a streamlined and consistent approach to the workday.

In short, reviewing your organization’s coding and compliance infrastructure and implementing best practices can ultimately protect your organization from compliance-related risks and increase your organization’s reimbursement in a cost-effective manner.

An examination of the activities highlighted above will ensure the charge submission process is efficient, claims are billed and adjudicated appropriately, and risk and subsequent expenses are mitigated.

Ben Colton is a principal and Chris Gaspard a senior consultant with ECG Management Consultants, a national consulting firm working exclusively with healthcare providers.
A: This sounds like you are describing some menu options your EHR gives you to “characterize” problems in the A/P. This perspective is uniquely yours as the provider creating the note. Coders don’t see this from your perspective as the notes are reviewed after they are done. It sounds like they’ve only given you three “flavors” to pick from—not nearly enough.

Coding resources use lots of words to describe “moderate” level decision-making: worsening, exacerbated, progressing, unstable, uncontrolled, poorly controlled, inadequate control, minor complication, inadequate response to treatment, uncertain prognosis—the list goes on.

They all seem to reflect “activity” or “not stable.” So to communicate the patient’s actual status, somewhere in there is the language you should use.

If your list of variable “descriptors” is editable, give yourself every version of the language above and add your own, such as: “patient’s overall condition improved but remains guarded due to multi-system disease.”

Be more specific and describe potential disease interactions. Sit down and think of the common ones, and their overall impact.

If you make a good list, pick from it as needed. And hopefully you can always add more.

Q: I saw a new patient that was recently discharged from rehab. Can I bill for a Transitional Care Management (TCM) code? Or not because I was not the patient’s physician until today?

A: The TCM codes are about transitioning back into the community and dealing with problems of at least moderate level complexity. They are not limited to a particular provider type, although they were designed with primary care in mind. You do not have to be the “owner” of the patient, or the problems, for you to assess them.

Two of the requirements that Medicare outlines are:

- The healthcare professional accepts care of the beneficiary post-discharge from the facility setting without a gap; and
- The healthcare professional takes responsibility for the beneficiary’s care.

If you meet these criteria, as well as the other TCM requirements, you are good to go.

Do remember though that only one provider can bill the TCM service per hospitalization.
How telemedicine expansion will affect physician practices

2018 may well go down as the year of telemedicine expansion.

Telemedicine, or healthcare facilitated by means of video, phone, or other telecommunications technology, has been around for decades.

Yet over the past year, major players across the healthcare industry have made significant investments in it. Pharmacy giant CVS introduced virtual care offerings to its MinuteClinics. The Cleveland Clinic announced that telemedicine would be a major component of future care across the health system. And telemedicine vendor Teladoc announced a new global initiative supporting remote care in more than 20 languages. And those are only a few of the telemedicine-related plans announced over the past few months.

These initiatives beg an important question: As corporate telemedicine offerings continue to expand, what will be the impact on physicians outside of major health systems?

“There is currently pressure on physicians to consider alternate shared services delivery models that telemedicine solutions can offer,” says Neha Sachdeva, MS, a director at KPMG’s Healthcare & Life Sciences practice, referencing new ways provider organizations can extend the services they offer using virtual care delivery methods. “But there is no one-size-fits-all strategy for telemedicine use.”

She argues that, with telemedicine platforms ranging from a few thousand dollars to tens of thousands, physicians need to think beyond the cool factor of recent telemedicine advances and consider how such systems will improve patient health and solve business needs.

UNDERSTANDING CORPORATE EXPANSION

Telemedicine, despite not being a new technology, remains a buzz word across the healthcare industry. And for good reason: Instead of costly and time-consuming in-person encounters, physicians can rely on video visits, smartphone photos or other means to assess, treat, and manage patients with medical problems.

Ana María López, MD, FACP, president of the American College of Physicians, says that a renewed focus on value-based care has brought telemedicine into the spotlight. “Telemedicine offers opportunities for significant savings. There is a strong case to be made for its use to expand patient access to care and to reduce medical costs,” she says. “So it’s not surprising that we are seeing more solutions out there.”

Take video conferencing in an ambulance, she says. EMTs can send information, including images or other important clinical data to the trauma team waiting at the emergency department. That can result in streamlining care and significant savings in time and treatment costs.

Sachdeva agrees. “There are a lot of pressures, certainly, to adopt this kind of solution,” she says. “But..."
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“Telemedicine offers opportunities for significant savings. There is a strong case to be made for its use to expand patient access to care and to reduce medical costs. So it’s not surprising that we are seeing more solutions out there.”

— ANA MARÍA LÓPEZ, MD, FACP, PRESIDENT OF THE AMERICAN COLLEGE OF PHYSICIANS

Technology

Telemedicine growth

“there are also internal drivers—to reduce wait times to see a particular provider, to offer patients, who are looking for more consumer-centric healthcare, more options about how to receive care, and to help streamline workflows for the providers themselves.”

William Morris, MD, MBA, Cleveland Clinic’s associate chief information officer, says their own foray into telemedicine is due to a combination of all of those factors. “First, it’s the right thing for patients, when appropriate, to see them where they are and create a high-touch experience at their convenience,” he says. “But telemedicine also offers a lot of operational efficiency.”

Morris argues that when physicians can answer questions and review tests remotely, it is more efficient for the provider, the practice, and the patient. “We’re trying to change the way we think about practice—because there’s not just one way to provide care. You should be able to get our clinical expertise without having to deal with our parking,” he says.

Daniel Barchi, MS, chief information officer at New York-Presbyterian Hospital, believes that telemedicine is poised to fundamentally change the way providers practice medicine—in practices of all shapes and sizes. New York-Presbyterian currently uses different telemedicine solutions for emergency department triage as well as for peer-to-peer physician communication—and Barchi says the hospital plans to expand its offerings.

“If we are not investing in this area and providing great care and service to our patients through it, we are not going to be prepared for the way medicine is delivered in the future,” he says.

FACTORS TO CONSIDER

But despite these motivations, as well as multiple studies suggesting that telemedicine provide outcomes equivalent to traditional in-person visits, some physicians remain skeptical about how the technology can benefit their practices.

A recent Healthcare Information and Management Systems Society analytics survey reveals that 55 percent of hospital respondents were not sure they would invest in telemedicine in the next two years. A 2017 Medical Economics survey looking at telemedicine adoption in smaller practices found that less than 20 percent offered such services.

In both studies, providers did see the value of implementing such platforms to promote efficiency. Yet they said the return on investment was not clear. Between the price tags on current telemedicine platforms and the unknowns regarding costs of liability insurance and payer reimbursements, many providers feel, at this point, the investment is too risky.

Contrast those with a 2018 survey by Software Advice, a consultancy that helps organizations select the right software, including telemedicine solutions, showing that 77 percent of consumers would be more likely to select medical providers that offer telemedicine services—and that the majority of patients who use telemedicine appreciate its convenience. The findings suggest phy-
sicians may be underestimating consumer interest in telemedicine options—both now and in the future.

Sachdeva says that as no two physician practices are the same, so no telemedicine strategies should be either. Before considering adoption, physicians should determine where, when, and how a particular option can benefit the practice—and its patients. She suggests providers look at their current patient base and see in which situations telemedicine may be appropriate. By developing inclusion and exclusion criteria by looking at specific cases—perhaps a remote visit for a regular check-in with a diabetic patient, but an in-person appointment for the same patient if he is complaining of neuropathy-like symptoms—practices can better determine whether a remote care delivery model is right for them.

Providers may benefit from building or leveraging relationships with other organizations to make the most of telemedicine platforms. For smaller practices, aligning with a hospital or partnering with other practices may help reduce some of the cost burden. Such relationships can also provide guidance about how to best deploy telemedicine programs. Sachdeva says creating successful remote offerings won’t be as simple as following in the exact footsteps of bigger organizations but smaller providers can learn what to do, and perhaps more importantly, what not to do. It’s important for finding the right telemedicine vendor, she says—one who can work with you to set up a system that meets your specific practice needs.

“It really all goes back to, ‘Why am I doing this? What case studies makes the most sense here? Who am I trying to target? How will it help improve care and lower costs?’” says Sachdeva. Providers who take the time upfront to answer those questions—and look closely at the factors that are driving them to consider telemedicine—will be at an advantage. They can then look to other healthcare organizations with similar drivers, or vendor partners who specialize in those areas, to help them find the way forward.

But it’s important, Barchi adds, that such analyses should be physician-led. “Where we’ve been most successful is letting our physicians tell us what issues they are facing and how telemedicine might help them better manage those issues—whether it’s reducing wait times in the emergency room or having an expert assist you on a complex surgery from 1,500 miles away,” says Barchi.

MOVING FORWARD

What can physicians outside large health systems do to counter corporate telemedicine expansion? To start: their homework. That means investigating where, when, and how remote care delivery models can help physicians treat patients, and the specific business cases practices hope to address through their use, Sachdeva says.

But it continues with knowing how telemedicine will link up with electronic health record (EHR) systems.

“Think about what kind of telemedicine solution you might use and what kind of documentation needs to be [in the EHR] to support the care delivery you’re providing—and your reimbursements.”

—NEHA SACHDEVA, MS, DIRECTOR, KPMG’S HEALTHCARE & LIFE SCIENCES PRACTICE

“Think about what kind of telemedicine solution you might use and what kind of documentation needs to be [in the EHR] to support the care delivery you’re providing—and your reimbursements,” she says.

Sachdeva adds that physicians also need to consider medical liability when adding telemedicine services. A practice’s malpractice insurance plan may need to change to cover remote care delivery. While many physicians may assume telemedicine will raise liability, it is not always the case. Doctors should discuss their options with their
Insurance provider, including what type of coverage makes the most sense for the platform they are implementing.

Product liability is a concern: if the technology isn’t considered to be reliable, the care can and will suffer. And practices need to review their insurance contracts, Sachdeva says. Telemedicine reimbursements can vary greatly from payer to payer—and providers may have to renegotiate some terms if they take on a telemedicine care model. “There are lots of pieces and parts to think about before deploying a system,” Sachdeva says.

He maintains that just because doctors are seeing patients virtually does not mean less work is involved than an in-person visit. “These visits still take time and are still leveraging a physician’s intellectual capital in terms of practice and expertise.”

**THE IMPACT OF TELEMEDICINE ON PRACTICES**

Telemedicine holds a lot of promise to help medical practices promote efficiency, reduce costs, and increase patient satisfaction. But Lopez cautions that it is just another tool in a clinician’s care delivery toolbox, not a healthcare panacea.

“As with any tool used to care for patients, it’s important to use it appropriately,” she says. “It’s important for physicians to take a long view, assess where it can appropriately answer the diagnostic questions at hand, and make sure they are doing the right clinical thing for each and every patient.”

Morris says that telemedicine scales well—from large health systems like Cleveland Clinic to smaller rural practices. By taking the time to plan, looking at everything from the financials to changes in practice workflows, even smaller practices can reap the benefits.

But consumer expectations will drive even the smallest providers to find ways to affiliate with organizations who can help them implement at least some telemedicine options. With telemedicine continuing to expand across the globe, patients, more and more, will expect access via telemedicine.

“Instead of calling a pager or service, the patient is going to expect a quick video visit. I think we’ll see adoption being less physician-driven and more consumer-driven as time goes on,” he says.

Morris cautions that no two practices are the same—and there are a multitude of experiences that telemedicine may augment at the provider level.

“Telemedicine can help with many different cases in a way that benefit the patient, the provider, and the financial systems without the burden of overhead involved with an in-person visit,” says Morris. “It’s a time where we can really reimagine the way we want to experience healthcare, as patients and as providers.”

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“I think any successful telemedicine program starts with a physician evangelist who uses facts and data to bring others along. Telemedicine isn’t something that can be done to physicians. It needs to be done with physicians.”

— WILLIAM MORRIS, MD, MBA, ASSOCIATE CHIEF INFORMATION OFFICE, THE CLEVELAND CLINIC
More physicians see value of pharmacists in their practices

by FRED GEBHART Contributing author

Just as hospital pharmacists moved out of the basement and into direct patient care in the 1980s and 1990s, outpatient pharmacists are moving out from behind the counter and into medical practices.

“There is a demand for pharmacists from the physician side in ambulatory care,” says Elizabeth Cuevas, MD, director of the Primary Care Transformation for Residency Clinics at Allegheny Health Network, a nonprofit eight-hospital academic medical system with facilities in Western Pennsylvania and Western New York. Allegheny is putting pharmacists into about 250 different practices that are part of its accountable care organization (ACO), a payment model in which the health system receives higher reimbursement if it improves quality and reduces costs.

“We’ve used our pharmacists for improved medication management, medication reconciliation, patient education and outreach, symptom management, disease management, and making sure patients are actually taking their meds,” says Cuevas. “Pharmacists have a natural role in practices.”

Allegheny isn’t alone in placing pharmacists in physician practices and ambulatory care clinics. Integrated health systems and larger group practices nationwide are moving in the same direction.

In the ideal arrangement, pharmacists are embedded in practices with 5 to 10 physician and non-physician practitioners, explains John Kennedy, MD, chief medical officer of AMGA, formerly the American Medical Group Association. “For smaller practices or areas that may be more remote, you can use telemedicine or share remote [pharmacist] support as long as you have a shared electronic health record.”

Allegheny is using embedded pharmacists and shared services, depending on the size and location of the practices. Practices with one or two providers usually can’t support a full-time pharmacist, but they can benefit by sharing the services of a pharmacist, according to the health system.

A group of small practices that are relatively close to each other might share a pharmacist who rotates through the different offices, for example. More distant locations might do better with video and data links to a central pharmacist.

Either way, pharmacists are part of the care team and their salaries are covered by the practice. Regardless of the specific arrangement, the goal is the same—to incorporate pharmacists into team-based patient care.

STARTING IN THE HOSPITAL

Allegheny’s decision to put pharmacists on patient care teams can be traced back 30 years, to when inpatient physicians began working with clinical pharmacists. Then, Michael Korczynski, PharmD, BCAP, came

HIGHLIGHTS

Putting a pharmacist in the office can bring quality and financial advantages, which is critical in value-based reimbursement models.

Physician arrangements with pharmacists could be as formal as a full-time medication specialist in the practice or as flexible as telephone consultation when needed.
on board as manager for Clinical Services, Pharmacy—Ambulatory Care.

“I had come from Kaiser Permanente and the VA, so I was familiar with an autonomous role for pharmacists,” Korczynski says. “But it was a foreign concept here.”

Even so, in the years before Korczynski started at Allegheny, its physicians and pharmacists had built up a strong relationship working together on the inpatient side, he says. “I started an anticoagulation service and working with a primary care practice. Physicians quickly latched onto the new-to-them services.”

Changes in physician education also helped foster physician acceptance of pharmacists on care teams, says Kennedy. Most younger physicians train with pharmacists on inpatient care teams. Once they join a practice, they expect the same access to a medication specialist, he says. Practices and health systems that can offer a pharmacist in the office have a hiring advantage as the physician shortage grows.

WHAT PHARMACISTS OFFER
Putting a pharmacist in the office brings quality and financial advantages, which is critical in value-based reimbursement models, such as Allegheny Health’s ACO.

“Like all things in healthcare, it is about the dollar,” says Paul Lebovitz, MD, vice chair of the Allegheny Health Network Medicine Institute. “The present model, which is physician-centric, is not getting us to that quadruple aim of better outcomes, lower costs, better patient satisfaction, and improving the work life of our healthcare providers. We are moving to a patient-focused model using team-based care. Pharmacists are an important part of the team and the model.”

Eric Maroyka, PharmD, BCPS, director of the Center on Pharmacy Practice Advancement at the American Society of Health-System Pharmacists (ASHP), says placing pharmacists in the primary-care setting ensures care is provided in the most cost-effective location. “We are seeing care moving toward a more preventative model and not just episodic acute care,” he says. “The sickest of the sick will be in hospitals. Anything that can be done on an ambulatory care basis will be done that way and that is where the maximum payment will be.”

A single physician cannot provide the same quality of care as a team that incorporates a pharmacist, says Lebovitz. "I have made a significant impact with patients, but I recognize that there is so much more I could have done with help,” he says. “That’s what this transformation of care is all about.” Patients have better outcomes in team models, he says, because there are more eyes on the patient from the entire team.

Pharmacists also can lower costs of administering services, improve physician efficiency, and curb physician burnout, says Lebovitz. Anything pharmacists and other team members can take off the physician’s

“We’ve used our pharmacists for improved medication management, medication reconciliation, patient education and outreach, symptom management, disease management, and making sure patients are actually taking their meds. Pharmacists have a natural role in practices.”

— ELIZABETH CUEVAS, MD, DIRECTOR, THE PRIMARY CARE TRANSFORMATION FOR RESIDENCY CLINICS, ALLEGHENY HEALTH NETWORK
plate saves money and gives physicians more time to spend with patients.

"It doesn't take physicians long to recognize that team-based care makes their lives easier," Lebovitz says. "They realize they are no longer responsible for everything, there are other team members who can and should be doing specialized activities. It allows our physicians to work at the highest level of their training. That makes their life better."

Helping physicians work at the top of their training also benefits pharmacists. They are information resources, not dispensing resources, Maroyka says. Pharmacists managing patient medications or developing opioid stewardship for the practice are working at the top of their training, which boosts job satisfaction.

**PHARMACISTS MAKE THEIR CASE**

Pharmacists working with clinics or practices is new territory for both pharmacists and physicians. Arrangements could be as formal as a full-time medication specialist in the practice or as flexible as a few hours of telephone consultation as needed. Either way, working more closely with clinics and practices begins with physician awareness.

Physician practice and clinic leaders may not know what pharmacists can do for them. For example, they may know that up to half of new scripts for chronic care meds are never filled; they may not know that pharmacists can help patients start to use their meds.

The key is for physicians and pharmacists to talk about practice problems, then showing how the two groups can help each other. The whole discussion is about improving outcomes, reducing costs, and boosting satisfaction, Korczynski says.

One resource for physicians is the American Medical Association's physician practice improvement strategies: STEPS Forward. For information on how and why to embed pharmacists in practices, visit their website.

The Alliance for Integrated Medication Management (AIMM) is another resource. AIMM, Apexus and ASHP sponsor the A3 Collaborative. The year-long program helps provider organizations such as Allegheny create value-defined initiatives to build population management strategies by implementing clinical pathways that integrate medical care and comprehensive medication management services.

"Practices are seeing more and more pressure to account for outcomes," says Todd Sorensen, AIMM executive director. "That changes the whole focus from quantity care to quality care."

**REIMBURSEMENT CHALLENGES**

The lack of provider status isn’t keeping pharmacists out of ambulatory care clinics and medical practices. But more pharmacists would be in more practices if they were recognized as providers and could bill directly.

"Forward thinking commercial plans are beginning to develop ways to pay for an office-based pharmacist. That is going to become a game changer when it becomes more common."

—KEITH T. KANEL, MD, MHCM, CLINICAL ASSOCIATE PROFESSOR OF MEDICINE, THE UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE

"Not having provider status has an impact at the executive decision-making level on whether or not to hire a pharmacist for the practice," says Kennedy.

When the pharmacist cannot directly bill for services and generate revenue, the practice must find other ways to support the role. That usually means looking at cost savings, which may not appear until the second or third year. That lag can slow adoption.

"Right now, the system is paying for pharmacists in practices," says Cuevas. The need
STUDY:
Embedded pharmacists improve care quality

By Jill Sederstrom Contributing author

Embedding a clinical pharmacist in established primary care patient-centered medical home practices can yield big benefits, according to a study in the Journal of International Medical Research.

The study found that diabetes and hypertension patients who participated in Intermountain Healthcare’s Collaborative Pharmacist Support Services (CPSS) program were more likely to achieve their disease management goals, improve their time to achievement, and increase their ambulatory encounters, compared to those not in the program.

Under the CPSS program, ambulatory care clinical pharmacists worked alongside physicians in Intermountain Healthcare’s Medical Group primary care clinics to treat adult patients with diabetes or hypertension. The pharmacists initiated and adjusted medications, and ensured medications were being used safely and effectively.

Pharmacists also reviewed medication lists after hospitalizations, lowered drug costs by switching to generic or lower tier medications, worked with providers to determine the optimal therapy for a given patient, and de-prescribed potentially dangerous medications, according to a statement from Intermountain Healthcare, located in Salt Lake City.

When pharmacists worked collaboratively with physicians to provide patient care, the study found that patients were:

- to achieve an A1c level less than 8%, 57%
- more likely to achieve their blood pressure goal, 93%
- more likely to achieve both disease management goals than those patients who did not participate in the CPSS program, 87%

The study included data from 359 patients who were enrolled into the CPSS program between July 2012 and April 2015. This data was compared to data from 999 patients who were not enrolled in the program.

to demonstrate a return on the pharmacist investment is slowing pharmacist hiring.

Though Allegheny Health is in the process of adding pharmacists to 250 practices, they currently only have them in a handful of clinics, Cuevas says. "The pharmacist is not able to bring in direct revenue, but you can see a decrease in 30-day readmissions, a decrease in morbidity, a decrease in ER admissions because you have a pharmacist doing medication management and reconciliation. It is a matter of recognizing that the costs you are saving are different from direct billing."

Pharmacy organizations are pushing for provider status at the federal and state levels, but that alone isn’t enough. Legislation must also allow pharmacists to bill at realistic rates.

“There is literature showing that when pharmacists are allowed to bill at higher levels, they can generate revenue to cover their salaries,” says Korczynski. “If the rules say pharmacists are providers, but they can’t bill at higher levels, provider status won’t help.”

Commercial payers are part of the picture as well. Change is coming, but slowly.

“Direct billing for pharmacy care out of medical practices is still in its earliest stages,” says Keith T. Kanel, MD, MHCM, clinical associate professor of medicine at the University of Pittsburgh School of Medicine. He was principal investigator for the Primary Care Resource Center Project. The CMS Innovation center project put pharmacists in primary care practices in parts of Pennsylvania and West Virginia. The project, which began in 2012, showed a 25% reduction in 30-day hospital readmissions and reduced 90-day costs of care by more than $1,000 per patient.

“Forward thinking commercial plans are beginning to develop ways to pay for an office-based pharmacist,” Kanel says. “That is going to become a game changer when it becomes more common.”

Editor’s note: This article was first published in our partner publication, Drug Topics.
Is your profitability declining?

HERE’S HOW TO RESPOND IN A SMART WAY

Few things are more unnerving than realizing your business is less profitable than it once was—or than you counted on.

The instinct to take immediate action is understandable. If you’re a physician, responding quickly to urgent situations is second nature. And after all, if your profit is suddenly on a lower trajectory, you may have reason to be concerned that you’re heading toward a personal financial emergency.

Though it’s natural to act fast, resist the instinct to attempt a quick fix. Here’s what to do instead.

Invest enough time to be sure you’ve accurately identified the problem.

First instincts about the causes of profitability problems are often incorrect. That’s why getting a handle on the root causes of your situation is crucial—before taking corrective action.

Start with a meticulous review of your financial statements and accounting data for the past few years. Compare each revenue source and expense line in detail, making sure you have all the information you need to compare apples-to-apples. For example, if your accountants have changed up your chart of accounts, ask them to help you dig into the expense and revenue ledgers to find any specific items that have increased or decreased significantly over time.

Carefully consider the impact of extraordinary items, lags, and run rates.

Be sure to review both year-over-year and month-by-month financial data.

Any one-time expenses or revenues (e.g., an unforeseen legal expense, preventable inventory spoilage, or unexpected income) should be separated out to determine underlying, standardized financial performance. This will help you avoid confusion about whether specific items constitute harmful trends or are simply timing differences or extraordinary items unlikely to recur.

Let’s say, for example, that you’ve hired a new physician during the year. At the end of the year, you may find that her revenue falls short of expectations. But it might be incorrect to
Financial Strategies

conclude that her production is not on target. Several types of lags could affect her total for that first year. Her productivity for the final two or three months of the year will tell you more about the pace she’s working at (her “run rate”) than the full-year figures. The effect of credentialing, billing, and payment lags on physician revenue should also be considered. Take a look at both billed amounts and collections to get a clearer picture.

Rejigger your accounting methods if necessary.

Practices that have acquired offices or launched new businesses sometimes fold those entities into the existing accounting. This simplifies accounting and bookkeeping, but makes it more difficult to identify the root cause of profitability problems that arise.

If you’re unsure whether individual business activities are contributing to profit (or by how much), the (admittedly tedious) exercise of separating out the financials can greatly improve your analysis. And if you’re considering acquiring a practice or adding a new office or business line in 2019, plan up front for tracking expenses and revenues in a way that allows you to efficiently report on their profitability, not just the performance of your business in aggregate.

More generally, regardless of practice structure, managers and accountants often differ in their preferences for tracking expense lines. If your financial reports show just a few general expense and revenue lines—each with many items rolling up into the totals—consider a transition to more granular accounting. While this will mean more upfront bookkeeping effort, being able to evaluate your numbers efficiently and effectively is invaluable—and can help you prevent profit problems before they start.

Know that revenue is often the problem.

Practices with unexplained or precipitous profit problems might first react by slashing expenses. Expenses are often not the root of the problem, though—and focusing on cuts may have limited impact. Cutting expenses can also make profit problems worse. For example, staff reductions may directly affect clinician productivity, and less marketing spend may translate to fewer new patients. Furthermore, expense cuts often lead to fear and erode morale, which can lead to turnover that can weaken financial performance even more.

Physicians and practice managers often turn to expense cuts first because they underestimate the degree to which revenue can be improved. Reimbursements may indeed be squeezed, but there are many drivers of your revenue you can influence significantly—and sometimes easily. Even small improvements in revenue drivers like timely billing and collections, accounts receivable management, scheduling, and no-shows will pay off again and again.

Revenue may also decline because of things going on outside your doors, such as a dip in the local economy, layoffs at a major employer, or new competition. Physicians and managers who are focused on day-to-day challenges may miss these bigger picture influences on practice performance. The impact of these externalities can be profound—but, on the plus side, they may present new revenue opportunities.

For example, when large competitors enter a local market, independent practices may be able to compete effectively by offering more convenient or personalized services.

When new employers or new health plans come on the scene, your practice can stand out by working flexibly with these organizations and targeting them for customized marketing efforts.

Be thoughtful when trimming expenses.

If it turns out expense cuts are needed, focus on ways you can cut that don’t undercut your productivity or penalize employees unnecessarily. For example, if a new internet service offers the same speed for less money, that’s a savings that goes right to the bottom line.

Be clear on what will be gained when making cuts to make sure they’re really worth it. For example, if you consider cutting support staff, it can be helpful to think about how much productivity will be lost. Often, the cost of keeping a medical assistant on staff is a lot less than the revenue that will be lost by eliminating the job, and that is without even considering the impact on morale that follows any job cuts.

“Practices with unexplained or precipitous profit problems might first react by slashing expenses. Expenses are often not the root of the problem.”

Laurie Morgan is a partner and senior consultant with Capko & Morgan, a healthcare consulting and practice management firm. Send your financial questions to medec@ubm.com.
any people think gender workforce disparities are a concern only for women. Some deny that it is really an issue, while still others acknowledge its existence but don’t think it’s a problem. However, gender inequity is pervasive in the medical field and affects everyone.

In 1963, President John F. Kennedy signed the Equal Pay Act into law. The goal of this act was to abolish pay discrepancy based on gender. In 2018, the gender pay gap has yet to be closed. It is actually widening among physicians.

While there are those who will argue it is due to women working less hours or taking time off to raise children, recent studies controlled for these factors and demonstrated consistently that the gap exists for the same number of hours worked at the same rank. This wage gap is not unique in the medical profession, but the gap for physicians is one of the largest.

Other gender inequities that exist in medicine are as follows:

- Female physicians in academic medicine are less often given faculty promotions or leadership roles, even when they are published at the same or higher rate as male physicians.
- Women are less often offered speaking opportunities, especially keynotes, grand rounds, and lectureships.
- Women are underrepresented on medical journal editorial boards.
- Female physician researchers receive less funding from the government, foundation grants, philanthropy, industry, and venture capital.
- Sexual harassment has been reported by 1 out of every 3 women in academic medicine.
- Female physicians often face discriminatory practices while pregnant and taking maternal leave. This discrimination has been well-documented in many areas.
- Female physicians experience a higher rate of burnout.
- Last year, women founders received only 2 percent of venture capital funding.
- It is obvious that many gender disparities still exist in medicine. But why should everyone care? Several studies demonstrated that organizations with diverse workforces actually did better financially. Additionally, compared to their male counterparts, female physicians have been demonstrated to have the same or higher clinical outcomes.

Intuitively, it makes sense that a happy workforce will be more effective.

Some argue these disparities are based on one of several myths: there are less women, women work less hours, they do not possess leadership skills, or do not want to advance. The fact is there are many equally qualified women who want to rise in the ranks of their career path.

Discrimination may not be overt, but the implicit bias engrained in the system has similar results. Many men support ending gender disparities, but this is not enough.

Discrimination may not be overt, but the implicit bias engrained in the system has similar results. Many men support ending gender disparities, but this is not enough.

Medical societies, hospitals, medical schools, funding sources, medical journals, and anyone in position to shape policy change must take the initiative to examine their own internal policies and create change. Once they have stamped out their own biases, they need to look at the system that perpetuates these disparities at large.

Linda Girgis, MD, is a family physician in South River, N.J. What do you think should be done to deal with the gender disparity in medicine? Tell us at medec@ubm.com.
Best advice ever given to you by a peer

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“One of my professors once told me the day you stop learning is the day you hang up your stethoscope.”

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Family Medicine
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